medTRANS Insurance:

General Risk Pool Underwriting Methodology

medTRANS Insurance, Ltd., a Nevada-domiciled sponsored captive facility, offering stop-loss coverage to self-funded employers through a unique, mutually owned risk pool. Our underwriting methodology ensures fair, transparent, and competitive pricing while empowering and encouraging employers to control costs and share profits through their own captive insurance companies. This document explains how employee health insurance populations are rated and helps understand and outlines the captive strategies benefits.

What is a Captive?

A captive is your own insurance company, allowing you to:

- Gain greater control over your health plan costs.
- Collaborate with other employers in the medTRANS general risk pool.
- Retain underwriting profits when claims are lower than expected.

Why Choose medTRANS?

- **Competitive Pricing**: Benefit from data-driven rates tailored to your group.
- **Low expense load**: The expense load is 3-4 times lower than group, reinsurance captives
- **Collaborative Governance**: Have a voice in how the risk pool operates.
- **Profit Potential**: Keep underwriting profits through your captive.
- **Unique structure**: Not the common, group, reinsurance captive.

How Your Group is Rated

Our underwriting process evaluates your employee population to determine specific stop-loss premiums and, upon request, aggregate stop-loss premiums. We use a transparent, data-driven approach certified by an independent actuary and approved by our Underwriting Committee, ensuring compliance with Nevada insurance regulations. Our rating is a combination of industry-standard rating methodology and medTRANS' experience.

Core Principles

- **Risk Ownership**: Employers actively manage unpredictable risks e.g., through cost mitigation programs to keep costs low.
- **Mutual Governance**: Employers contribute to the governance of medTRANS, fostering collaboration and fairness.
- **Profit Motivation**: Employers maintain single-parent captives to accumulate profits, rewarding effective risk management.

The Underwriting Process

Our process, illustrated below, ensures accurate and competitive pricing.

Exhibit A: The Underwriting Process Flowchart

Workflow Overview

Step 1: Receiving a Request for Proposal (RFP) by sending data to rfp@completecaptive.com

We receive RFPs from:

- Health insurance consultants.
- Health plan service providers.
- Employers directly.

What We Need (see Exhibit B: Data Standards)

- **RFP Questionnaire**
- **Employee Census**: Age, gender, dependents, and zip code.
- **Up to date Claims History**: 24 months, including, 50% notices & large claims >$50,000
- **Policy History**: Current and incumbent renewal offer
- **Health Plan Design**: Deductibles, copays, and covered benefits.
- **Current Health Plan service provider stack**: Named TPA, PBM, Managed care, etc
- **Anticipated Health Plan service provider vendors**

Step 2: Data Analysis

We prioritize the following data, in the following order of importance:

- **Claims History**: Frequency, severity, and cost per employee per month (PEPM).
- **Employee Census**: Demographics and enrollment details.
- **Health Plan Design**: Cost-sharing features (e.g., deductibles).
- **Benchmarks**: Industry and regional standards (e.g., Milliman data).

Step 3: Underwriting Guidelines

Our guidelines ensure fair risk assessment:

- **Group Size**: Minimum 20 participating employees.
- **Demographics**: Age and gender analysis, with a strict average age of less than 50.0 years for participating employees as of the policy's effective date.

- **Claims Analysis**: PEPM compared to industry norms; groups with PEPM >1.5x norm may require adjustments (e.g., lasering).
- **Risk Mitigation**: Wellness programs (e.g., fitness incentives) preferred.
- **Actuarial Models**: Use predictive modeling and industry-standard annual medical cost trends.
- **Lasering**: Higher retentions for high-risk participants, disclosed clearly.

Step 4: Deny to Quote (DTQ) Checklist

We may decline to quote if:

- Group has fewer than 20 participating employees.
- Group's average participating employee (not inclusive of dependents) age is greater than 50 years as of the policy effective date.
- Claims data is incomplete or appears to be incomplete, as determined by the Underwriting Director.

Step 5: Proposal Generation

Indications or Proposals, delivered within 5-10 business days, include:

- **Specific Premium**: Covers an individual with claims above retention.
- **Aggregate Premium**: Covers total plan losses above an attachment point (e.g., 1xx% of expected claims).
- **Aggregate Factor(s)**: Health Plan cost per employee per month (PEPM)
- **Lasering Details**: If applicable.

How Premiums Are Calculated

Specific Premiums

Based on:

- **Claims History**: Frequency of severity of large claims.
- **Demographics**: Age/gender adjustments (see Exhibit C: Sample Age/Gender Table).
- **Plan Design**: Higher deductibles lower premiums.
- **Lasering**: High-risk employees increase premiums. Lasers carve out the risk (or a portion) to be retained by the employer. Lasering keeps premiums stable for the remainder of the enrollees.

Aggregate Premiums

Based on:

- **Expected Claims**: From claims history and trends.

- **Attachment Point**: Typically 1xx% of expected claims.
- **Group Size**: Smaller groups have higher risk adjustments.

Aggregate Factor

Set at 1xx% of expected claims, adjusted for:

- Risk of unpredictable claims (higher for smaller groups).
- Plan design (strong cost-sharing reduces risk).
- Industry benchmarks (e.g., Milliman, Mercer).

Sample Scenario: Rating Your Group

Consider a 50-employee group in Nevada with:

- **Average Age**: 40 years.
- **Claims History**: $400 PEPM (within industry norms).
- **Plan Design**: $1,000 deductible, 20% coinsurance.
- **Wellness Program**: Smoking cessation initiative.

Our Process:

- Total project expected claims: Age/Gender table results = $240,000/year
- Adjust for demographics: Specific age/gender distribution.
- Set specific premium: $150/employee/month for claims above $50,000.
- Set aggregate attachment point

Result: Total premium ~$7,600/month, competitive with market rates.

Why medTRANS Stands Out

Unlike traditional stop-loss carriers (e.g., those offering only risk transfer), medTRANS offers:

- **Profit-Sharing**: Retain underwriting profits through your captive.
- **Collaboration**: Shape the risk pool through mutual governance.
- **Tailored Pricing**: Rates reflect your group's unique risk profile and risk management efforts.
- **Unique captive structural attributes**: Single-parent captive ownership has favorable accounting benefits.

Our Pricing Philosophy

medTRANS uses industry benchmarks (e.g., Milliman, Mercer) to ensure competitive rates. We reward proactive employers with lower premiums, balancing affordability with the financial stability of our risk pool.

Glossary of Terms

- **General risk pool**: medTRANS may, from time to time, develop a risk pool customized to the needs of certain participating single-parent captives. When a risk pool develops, it may desire to deploy its own set of Underwriting Methodologies.
- **PEPM**: Per Employee Per Month claims cost.
- **Lasering**: Higher premiums for high-risk employees to protect the group.
- **Attachment Point**: Claims threshold for stop-loss coverage.
- **Aggregate Factor**: Percentage of expected claims for aggregate coverage.

Supporting Tables

Our underwriting uses data-driven tables, including:

- **Age/Gender Table**: Rates by age and gender.
- **Zipcode Table**: Regional cost adjustments.
- **Health Plan Design Table**: Adjustments for deductibles/copays.
- **Frequency of Severity Table**: Large claims data by group size.
- **Enrollment Standard Table**: Minimum participation (e.g., 75% of employees).

For examples, see the Age/Gender and Zipcode Tables in the referenced artifacts.

Next Steps

To ensure this methodology serves our clients and stakeholders effectively, we are committed to the following actions:

- **Stakeholder Review and Feedback**:
    1. Share this document with health insurance consultants, employer clients, and risk pool participants.
    2. Collect feedback on clarity, usability, and alignment with client needs.
    3. Incorporate suggestions to refine the document before finalization.
- **Actuarial Validation**:
    1. Engage an independent actuary to validate and finalize rates in the Age/Gender, Zipcode, and other supporting tables.
    2. Ensure all actuarial models (e.g., medical cost trends, aggregate factors) reflect current industry standards.
- **Regulatory Submission**:
    1. Submit the finalized methodology to the Nevada Division of Insurance for formal approval.

2. Address any regulatory feedback to maintain compliance.

Exhibit A: Underwriting Flow Chart

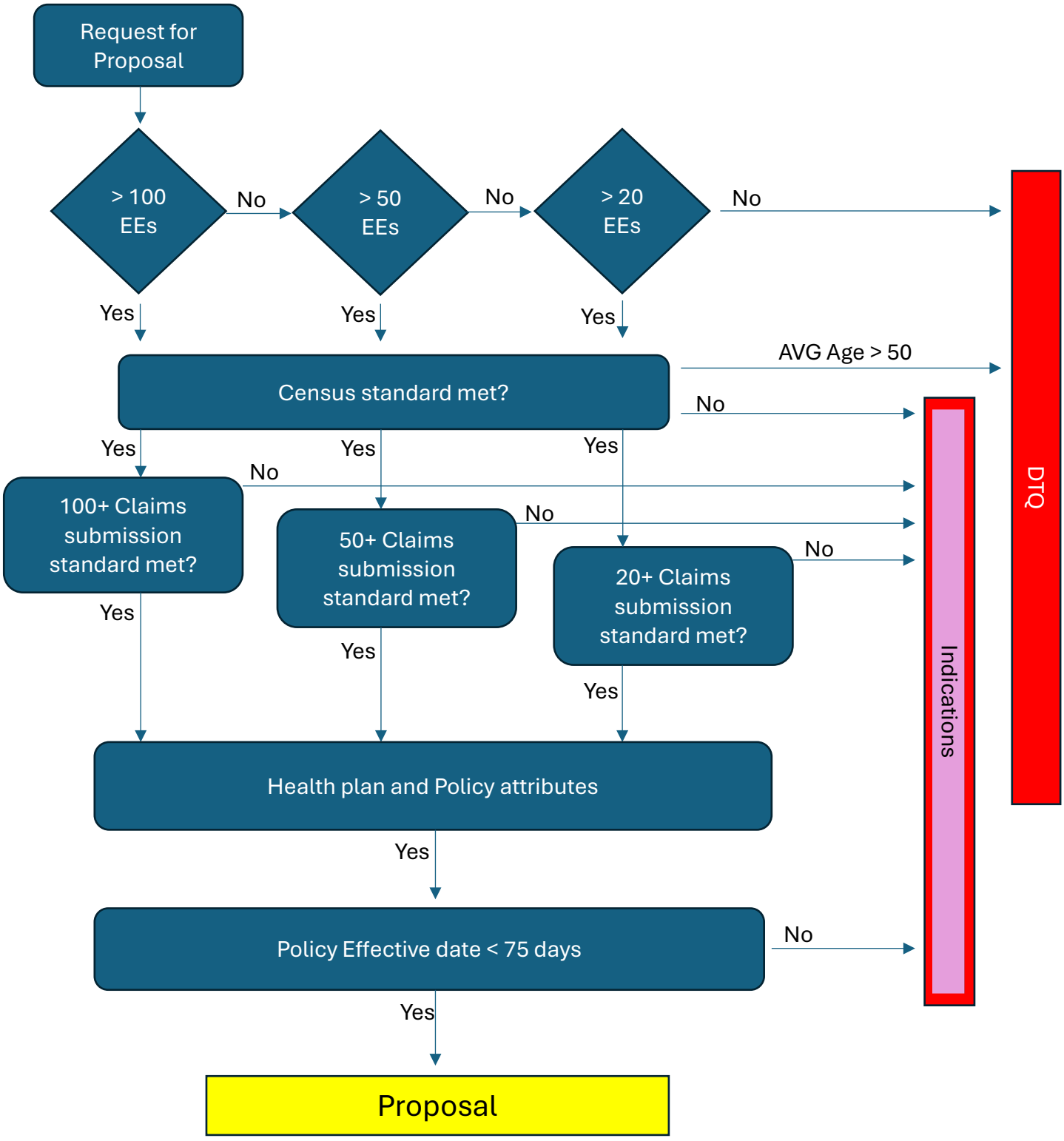

Exhibit B: Data Standards

Census Standard

Census Standards	In Excel format, either XLS or
	Must include member name or some identifier
	Employee gender must be expressed as either M for Male or F for Female. When expressions are not in this format, or a format that can't be easily understood, all non-conforming will be rated as a Female.
	Employee date of birth, expressed in a format such as xx/xx/xxxx or xx/xx/xx. Policy wide participant average age will be calculated as of the desired policy effective date. **Employee's dependent** (if they seek coverage under the employer sponsored plan) date of birth also in an identical format.
	Employee's residential zipcode. Employee's dependent's zipcode. If the dependent's zipcode is not provided, it shall be assumed the dependent's zipcode matches the employee's.
	Employee's desired coverage tier as of the future policy's effective date.
	If the employer offers multiple plan designs, then the census must include the design the employee has elected, as of census remittance date.
Census template	https://medtransuw.com/upload/CensusFileFormatTemplate.xlsx

Claims Standard

Claims Standard: >100 EEs on the plan

Claims Standards	No less than 9 months of Month over month aggregating claims, "Agg report"
	Specific and aggregate claims paid within this policy period
	Pending and/or disputed claims within the current policy period
	"50% report" of claimants breaching at least 50% of the current specific deductible or $50,000, whichever is less
	Clinical reports on claimants currently in case management and/or expected to be an ongoing breach of specific retentions, including LASER retentions

Claims Standard: > 50 but < 100 if self funded

Claims Standards	No less than 9 months of Month over month aggregating claims, "Agg report"
	Specific and aggregate claims paid within this policy period
	Pending and/or disputed claims within the current policy period
	"50% report" of claimants breaching at least 50% of the current specific deductible or $50,000, whichever is less
	Clinical reports on claimants currently in case management and/or expected to be an ongoing breach of specific retentions, including LASER retentions

Claims standard: >50 but < 100 if fully insured

Claims Standards	IF Available, month over month of claims against premium paid
	IF Available: Severity claims over the identified pooling point
	IF Available: Identification of the number of claimants who have breached the stated pooling point
	Underwriter AND Management has the authority to respond to the RFP with a Deny to Quote response for whatever reason.

Claims standard: < 50 EEs on the plan

Claims Standards	IF Available, month over month of claims against premium paid
	IF Available: Severity claims over the identified pooling point
	IF Available: Identification of the number of claimants who have breached the stated pooling point
	IF Premiums appear overtly high and/or loss ratio submitted reports greater than 100% and/or the incumbent renewal offer is greater than 25%, the Underwriter has authority to respond to the RFP with a Deny to Quote response.

Health Plan and Policy Attributes

Plan Sponsor	Business name of Employee Benefits Plan Sponsor
	Desired Third Party Administrator, if applicable
	Desired Pharmacy Benefits Manager, if applicable
	Engaged health plan consultant, if applicable

Health Plan Standards	Current and desired health plan designs, to include desired deductible(s), Co-Pay(s), Max out of Pocket(s) at minimum
	Current and desired managed care network and/or some other claims discounting service provider
	Any health plan point solution providers

Policy Standards	Current insurance policy
	Incumbent policy renewal offer

Exhibit C: Sample Age/Gender Table

Male	Cost	Female	Cost
1	$5.219	**1**	$5,882
5	$1,902	**5**	$2,238
10	$1,590	**10**	$1,603
15	$1,930	**15**	$2,050
20	$2,005	**20**	$2,940
25	$2,210	**25**	$3,041
30	$2,569	**30**	$3,989
35	$2,953	**35**	$4,040
40	$3,310	**40**	$4,520
45	$3,910	**45**	$6,070
50	$5,188	**50**	$6,210
55	$7,102	**55**	$5,910
60	$9.810	**60**	$6,070
65+	$11,490	**65+**	$9,529
		Total Plan cost	$x,xxx,xxx